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DISCUSSION

Dr Jon Matsumura (Chicago, Ill). Thirty-eight percent of the patients in the fem-pop group had Rutherford class 4 to 6 vs 18% in the endo group. Did you look at results stratified by CLI or do you have a multivariate analysis? Patency results may be influenced by the fem-pop group being enriched with patients with more severe ischemia.

If you did PTA and it looked beautiful, why did you still place a stent-graft? Did you consider having an arm with PTA and selective application of the device?

Dr John C. Kedora. We did not consider doing simply a PTA arm. We went into this study design with the thought that we would primarily treat patients with the stent graft, regardless of whether or not their PTA result was adequate. Our experience has shown this to give better long-term patency. As far as dividing into a subset of chronic limb ischemia categories, we did not stratify the data by that method.

Dr Enrico Ascher (Brooklyn, NY). Did you balloon angioplasty the lesion before placing the stent or did you place the stent graft and then balloon it?

Dr Kedora. All lesions were predilated by angioplasty and then the stent graft was placed. The stent graft was then modeled with angioplasty post deployment as well.

Dr Ascher. And how many of these were above the knee and how many were below the knee?

Dr Kedora. All these were placed above the knee.

Dr Takao Ohki (Bronx, NY). I wasn't quite sure about your inclusion criteria. But if I may recall, you said that the patient was enrolled if the lesion, based on the CTA or angiogram, appeared to be appropriate based on an attending's opinion. After all, you had a number of TASC Type A lesions, as well as B, C and D.

In the TASC document it does say clearly that TASC A is better treated with interventional treatment, whereas TASC D is best treated with bypass. The real question is what to do with TASC B and C. You should have randomized these patients, then it would have been a much more valuable study.

Dr Kedora. I think you are right that the evidence for TASC A lesions is that they are definitely better treated with endovascular means. I also believe, at least in our study, we wanted to do a true randomized, prospective study. All patients were well informed of the chance that if they had a less significant lesion that there was the chance that they would undergo a surgical bypass and, fortunately, we had patients that agreed to both.

Dr Kenneth Ouriel (Cleveland, Ohio). Sometimes when you do a study, you become an expert in a technique and you employ that technique in patients outside of the scope of the study. And so I have a somewhat politically charged question for you. What do you think about using these devices for popliteal aneurysms with the distal portion of the stent graft below the level of the knee joint?

Dr Kedora. Evaluation for treatment of popliteal aneurysms with this graft have yet to be done. In most cases, in our treatment group, there was disease in the proximal portion of the popliteal artery, and we were comfortable with placing the stent graft, at least in the proximal portion.

Dr Ouriel. Did you use these at all in patients that needed the distal to be below the level of the knee joint?

Dr Kedora. No, sir, we did not.